#2 acceptable

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS C/O #26200, #26203, #26232, #26779, #26871, #26879, 27171, #27223, #27253, #27271, #27297 and #27531 were investigated February 7-22, 2011, at Norris Health and Rehabilitation Center. No deficiencies were cited for C/O #26200, #26203, #26232, #26779.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation and interview, the facility failed to update the care plan for one resident (#6) with a wound and one resident with falls (#14) of twenty-two residents reviewed.	F 279	F279 **HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENCT PRACTICE?** Resident #6 Care Plan updated by the DON to reflect the skin condition on 3/1/11 Resident #14 Care plan was updated by the unit manager to reflect the falls on 2/24/11 **HOW WILL THE FACILITY IDENTIFY OTHER RESIDENT S HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** All current residents received a head to toe skin assessment on 2/28/by the licensed nurses working this day and the DON, Unit Managers and no new non-identified skin issues were identified. The residents with previously identified skin issues had a Medical record review to determine if a Care Plan was in place. All residents who experienced a fall since 3/1/11 were reviewed by the DON to determine if a care plan for accidents and prevention efforts was in place.	3/28/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mike Cassell RN NHA | TITLE: Adm. | (X6) DATE: 3/18/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 The findings included: Resident #6 was admitted to the facility on March 14, 2006, with diagnoses including Severe Dementia, Alzheimer's Disease, Hypertension, Seizure Disorder and Peripheral Vascular Disorder. Medical record review of the Minimum Data Set (MDS) dated October 28, 2010, revealed the resident had short and long-term memory problems and severely impaired decision-making skills; was totally dependent on staff for all activities of daily living; and had no ulcers, wounds or other skin problems. Medical record review of the care plan revealed no documentation the resident had any lower extremity ulcers. Review of the facility's policy for skin management revealed, "...Lower extremity ulcers ...3. Care Plan is updated to reflect the new problem and interventions with evaluation and revision documented on an ongoing basis ..." Observation on February 7, 2011, at 10:35 a.m., revealed the resident was positioned in a reclined geri chair with a gauze bandage on the right lower leg. Observation and interview on February 7, 2011, at 11:00 a.m., with the Registered Nurse (RN) #1/Treatment Nurse confirmed the size of wound was 1.5 cm (centimeters) X (by) 1.2 cm and had a "slight raised center" with a small amount of serosanguineous (serum and blood) drainage. Medical record review and interview with the Director of Nursing on February 8, 2011, at 3:30	F 279	**WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** Licensed Nurses were in-serviced on 3/11/11 addressing by the SDC regarding: A) weekly skin check and Care plan need for identified wounds. B) Addressing the need to update the care plan for falls and incorporating new interventions for each fall. (3 PRN nurses are left for in-servicing- they will not be allowed to work until in-service is completed) Clinical leadership (DON, Unit Managers) were in-serviced on 3/18/11by the Admin, and SDC regarding updating care plans to include safety devices and Post fall interventions as well as Care Plans for skin impairments. A weekly wound report is developed utilizing the weekly skin checks and weekly wound measurements and assessment forms. This report will be used by the DON, Unit managers to audit the medical records of 3 random charts weekly for 4 weeks then monthly time 3 months to determine if the Care Plans are in place. The facility will conduct a weekly Action Team Meeting to review Incidents and Accidents and during this process is completed to determine if the care plans are in place.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 p.m., in the Social Worker's office confirmed the care plan had not been updated to reflect the wound on the right lower leg or interventions related to the wound. Resident #14 was admitted to the facility on May 27, 2010, with diagnoses including Dementia, Gastrointestinal Reflux Disease and Fractured Hip with Left Heml-Arthroplasty. Medical record review of the MDS dated December 7, 2010, revealed the resident had no impairment of decision-making skills; required extensive assistance with bed mobility, transfers and ambulation; was unsteady when moving from a seated to a standing position, ambulating, moving on and off the toilet and transferring between the bed and chair; was incontinent of bowel and bladder; and had a history of falls in the prior one to six months prior to admission. Medical record review of the "Fall Risk" assessments dated May 27, June 3, September 7, and December 7, 2010, revealed the resident was at high risk for falls. Review of a "Change of Condition" dated December 12, 2010, revealed, " ...Heard clip alarm. Found resident in floor sitting up beside bed ...no injuries noted ..." Review of the facility's "Interdisciplinary Post Fall Review" dated December 12, 2010, revealed, " ...Had slid off ...bed ...will apply bolsters as long as air mattress in use ...Intervention Recommendations: ...clip alarm ..." Medical record review of the care plan dated December 7, 2010, revealed the care plan had not been updated to include a clip alarm as an intervention to reduce the risk of falls.	F 279	**HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** The DON or Unit Managers to determine if the system is working will review results of the weekly random audits of Wounds and Incidents. If issues are identified then modification will be made via the QAA committee. The QAA committee will review these audits monthly for 4 months.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 Review of the facility's policy for fall management revealed, " ...The IDT (Interdisciplinary Team) then modifies and implements a Care Plan and treatment approach to minimize repeat falls. The Care Plan will be reviewed/revised as indicated ...If a Fall Care Plan is not current, arrange to have it updated ..." Observation and interview on February 15, 2011, at 9:25 a.m., with LPN #1 confirmed the clip alarm was not attached to the resident. Observation and interview on February 16, 2011, at 1:23 p.m., with RN #2/Staff Development Coordinator confirmed the clip alarm was not attached to the resident. Medical record review and interview with LPN #1/Unit Manager, on February 15, 2011, at 9:30 a.m., confirmed the care plan had not been updated to include the clip alarm as an intervention to reduce the risk of falls. C/O #26879	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide written medical information to the hospital to which one resident (#9) was transferred of twenty-two residents reviewed.	F 281	F281 HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENCT PRACTICE? Resident # 9 was discharged from the facility due to behavior issues and was escorted via the Police department. No further interventions can be made at this time for this resident.	3/28/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 4 The findings included: Resident #9 was admitted to the facility on October 14, 2010, with diagnosis of Traumatic Brain Injury related to a motor vehicle accident. Medical record review of the Minimum Data Set dated October 21, 2010, revealed the resident had impaired cognitive skills and memory problems; required limited assistance with transfers, ambulation in the room and hallways; and used a walker for mobility. Medical record review of Social Worker documentation dated November 2010, revealed the following: November 3-"Room (changed due to) resident behaviors (with) roommate, plans and goals discussed info to (Rehabilitation Hospital) for possible admission..."; November 8-"(Mental health) order to eval (evaluate)...psychosis management of bipolar disorder...behavioral/mood issues..."; November 7-"Room (change)...D/T (d/t) erratic behavior "standing over roommate yelling..."; November 16-"(Rehabilitation hospital) denied transfer to their unit..."; November 17-"Spoke (with) son...resident (not) appropriate for this environment..."; November 17-"Faxed info (information) to (acute care hospital #1) for behaviors...(no) beds available..."; November 17-"Info faxed to (behavior unit)..."; November 19- "(Increased) behavior mood (change)...Order...to send to (acute care hospital #2) for eval..." and November 19- "Resident returned 11-19-10 to facility from hosp (hospital) eval. Will continue to try et (and) find placement more suitable. Staff monitors resident's whereabouts, has wander guard on d/t (due to) risk of elopement..."	F 281	**HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** A record review by the DON of the transfers since 3/1/11 to acute care facilities was reviewed to determine if transfer information, medical information was sent with the resident. All transfers had appropriate information sent with the resident. **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** The Licensed Nurses were in-serviced by the SDC on 3/11/11 regarding the necessary documentation for all transfers including transfer form, Orders and History and Physical. DON or Unit Managers will audit up to 5 transfers each week times 4 weeks then monthly times 3 months to determine if the appropriate transfer information was sent.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 Medical record review of a physician's order dated November 30, 2010, revealed, "Send...to (hospital)...to evaluate for medical clearance for (mental health institute) because pt. (patient) is a threat to others-pt. can not remain in (facility) because we can not meet...needs." Medical record review revealed the resident was transferred to the hospital and returned to the facility on November 30, 2010. Medical record review of documentation by the Social Worker dated December 2010, revealed the following: December 14, at 1:35 p.m.-"Called son...again re(regarding) DC (discharge) to his care. Son very aggravated at health system...informed son resident DC'd (discharged) at 12 pm...Son needs to pick pt up now...has been discharged with lengthy notice. Son very verbally abusive, using profanity. SS (Social Services) informed son pt (patient) is now being aggressive, wandering and potential for combativeness in facility...must come et pick...up..."; December 14, -"SS called 911...to remove resident to hospital D/T agitation, combative actions et hollering in hallways..."; December 14, at 5:30 p.m.-"...removed from facility via hand-cuffs (with) assist of two officers. Report called to (hospital #2)...very combative, belligerent...unstable actions...Informed (hospital staff) pt. can not return to facility..."; December 15-"Resident was returned to (facility) on December 12/14/10..."; December 15, at 2:15 p.m.-"Info faxed to (another long-term-care facility)..."; and December 15, at 6:25 p.m.-"Info faxed to (another facility)..." Continued review of Social Worker notes revealed the following: December 16, at 3:00 p.m.-"...wandering throughout facility becoming increasing agitated. Staff 1:1 (one-on-one) continuously due to	F 281	**HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** Results of the random transfer audit will be presented to the monthly QAA committee for review. If identified issues are determined then adjustments to the plan of correction will be made. QAA committee will monitor this for 4 months or longer depending if this plan is successful.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 6 aggression. Very belligerent, hollering out sporadically at others causing more disruption..."; 3:15 p.m., "Called 911 for assistance et removal of pt. Unable to meet needs et safety of self et others. Moods et behaviors uncontrollable. Officers arrived at facility (...5 officers) for removal. Called (hospital #3) to inform of removal from facility due to aggressive behaviors...spoke with charge nurse...gave report of...aggressiveness, a harm to self et others, poor family support, abusive behavior. Explained in depth patient is not to be returned to (facility) due to uncontrollable moods/behaviors, unsafe et harmful to others is a high risk..."; 10:51 p.m. -"...Spoke (with) charge nurse...explained situation et could not accept pt back due to safety risk et possible harm to self et others...charge nurse stated...felt pt was dumped on them et there was no reason for him to be admitted to (hospital #3)..."; and at 11:35 p.m., "Case Mgr (manager)...(hospital #3) contacted SS...Stating... (hospital #3) is not a Mental Institution. SS informed her (facility) can not accept...back due to safety risk...will fax info directly to her in a.m. on 12/17..." Medical record review (hospital #3) revealed the resident was received at the hospital ER (Emergency Room) at 4:50 p.m., on December 16, 2010, and was discharged to the care of the son on December 17, 2010, at 11:17 p.m. Medical record review of the ER triage report dated December 16, 2010, revealed, "No med list sent to ER." Telephone interview on January 21, 2011, at 9:10 a.m., with the Compliance Officer at hospital #3 confirmed the resident was transferred to the ER on December 16, 2010, and no transfer	F 281		

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 7 information, including a list of the resident's medications were provided to the hospital. Continued interview with the Compliance Officer confirmed the hospital did not receive any written information on the resident until the facility faxed information to the hospital on the morning of December 17, 2010. Interview with the facility's Social Worker on February 8, 2011, at 10:00 a.m., in the Social Worker's office confirmed the resident was transferred to the ER of hospital #3 "around 4:30 or 5:00 p.m.," on December 16, 2010, and confirmed written transfer information including a list of the resident's medications was not provided to the hospital until the following morning on December 17, 2010. Interview with the Director of Nursing (DON) on February 8, 2011, at 10:12 a.m., in the Social Worker's office confirmed a Change in Condition form, History and Physical, and medication list was placed in an envelope and sent to the hospital when residents were transferred to the hospital. Continued interview with the DON confirmed the Change in Condition form, History and Physical and medication list had not been provided to the hospital (#3) at the time resident #9 was transferred on December 16, 2010. C/O #27253	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure repositioning and incontinence care was provided for one (#19) of twenty-two residents reviewed. The findings included: Resident #19 was admitted to the facility on December 17, 2010, with diagnoses of Persistent Vegetative State, Deep Vein Thrombosis, Contractures, Tracheostomy, Traumatic Brain Injury, Quadriplegia, Chronic Decubiti (Pressure Ulcers) and Urinary Tract Infection. Medical record review of the hospital Discharge Summary dated December 17, 2010, revealed, "...continues to be bedbound...Chronic Decubitus Ulcers...local care, turn every 2 hours..." Medical record review of the MDS dated February 4, 2011, revealed the resident was in a Persistent Vegetative State; was totally dependent on staff for all activities of daily living; had a feeding tube; and had one Stage 1 and three Stage 4 Pressure Ulcers. Medical record review of the resident's care plan dated February 4, 2011, revealed, "...Turn and reposition while in bed frequently for comfort and pressure reduction...Provide incontinence care after each incontinent episode..." Observation on February 22, 2011, at 10:20 a.m., revealed RN #3 and Certified Nursing Assistant (CNA) #3 positioned the resident on the right side. Observation revealed a Pressure Ulcer on	F 312	F312 **HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENCT PRACTICE?** Resident #19 was provided incontinent care and was repositioned once identified. Resident has a care plan for incremental turning and repositioning due to the cranial issues and his limitations of turning secondary to Traumatic brain injury. **HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Residents who are dependent for repositioning and who are incontinent are at risk for this practice.	3/28/11

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 9 the right lower buttock, one on the coccyx and one on the left buttock. Continued observation revealed the resident had been incontinent of a small to moderate amount of dark stool. Interview with RN #3, at the time of the observation confirmed the resident was in need of incontinence care. Interview on February 22, 2011, at 11:10 a.m., at the nurses' station, with CNA #1 revealed CNA #1 "came on duty at 6:00 a.m.", and relieved the night shift CNA. CNA #1 reported, "...not assigned to (resident) today...just come over to help out..." Continued interview with CNA #1 revealed the resident was positioned on the side at 6:00 a.m., when CNA #1 took report from the night shift CNA and confirmed CNA #1 had not turned or repositioned the resident or checked the resident for incontinence since coming on duty at 6:00 a.m. (five hours). Interview on February 22, 2011, at 11:15 a.m., at the nurses' station with CNA #2, who was assigned to the resident, confirmed CNA #2 came on duty at 7:00 a.m., and had not turned, repositioned or checked the resident for incontinence from 7:00 a.m., until 11:00 a.m. C/O #27531, #27223	F 312	**WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** The facility has developed a Resident kardex system- assignment sheet listing incontinent needs as well as turning/repositioning needs and will be updated daily M-F by the Unit Managers. The Resident Care Specialist were in-serviced by the SDC on 3/11/11 regarding Incontinence care and turning expectations for dependent residents using the electronic kardex system format. Unit Mangers will randomly audit the kardex of 5 residents weekly times 4 weeks then monthly times 3 months then as needed to determine if the kardex list the Incontinence needs and turning needs for dependent residents and that the turning and incontinent care is provided. A weekly review of the Kardex system will be made by the DON to determine if the kardex is in place for all residents.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314	**HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** Results of the random audits of the Unit managers and the DON will be presented to the QAA committee for 4 months. If issues are identified then modifications to the plan of correction will be made.	3/28/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review and interview, the facility failed to complete Pressure Ulcer risk assessments and/or weekly wound assessments for one resident with a Pressure Ulcer (#10) and failed to complete a dressing change as ordered by the physician and to provide timely repositioning and incontinence care for one (#19) with Pressure Ulcers of twenty-two residents reviewed. The findings included: Resident #10 was admitted to the facility on October 19, 2010, with diagnoses including Cancer of the Base of the Throat, Malnutrition, Anxiety, Hemiparesis (paralysis on one side), Tracheostomy and History of Cerebrovascular Accident (Stroke). Medical record review of the Minimum Data Set (MDS) dated January 5, 2011, revealed the resident had no discernible consciousness and was totally dependent on staff for all activities of daily living. Medical record review of the nursing admission assessment dated October 19, 2010, revealed a Stage 2 wound on the left sacral area, "...0.03 cm (centimeter) X (by) 0.03 circular opening..." and a Stage 1 on the coccyx "with Duoderm cover." Medical record review of the care plan dated October 26, 2010, revealed the resident had a Pressure Ulcer and revealed, "...Measure and stage wound weekly using the pressure ulcer healing assessment form..."	F 314	F314 **HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENCT PRACTICE?** Resident #10 is not longer at the facility and no further actions can be taken for him. Resident #19 received incontinent care and incremental re-positioning once identified **HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Residents who are at risk for skin breakdown and dependent for repositioning are at risk. **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** The facility has developed a Resident Care Specialist Kardex system assignment sheet listing the Incontinence and repositioning needs of residents that will be updated M-F by the Unit Managers.	3/28/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 Medical record review of the "Braden Scale-For Predicting Pressure Sore Risk" assessment dated October 19, 2010, revealed the resident was at risk for the development of Pressure Ulcers. Medical record review revealed the resident's risk of developing a Pressure Ulcer was not assessed again until November 24, 2010. Medical record review of the weekly Pressure Ulcer records dated November 29, 2010, revealed the resident had a Stage 2 wound to the left heel which measured 2.3 cm X 1.8 cm. Continued review of the weekly skin assessments dated December 15, 22 or 28, 2010, revealed the Stage of the wound had not been assessed. Medical record review of the weekly Pressure Ulcer records dated December 5, 2010, revealed the resident had a Stage 3 wound on the "buttocks, coccyx, sacrum" which measured 8.1 cm X 12.5 cm. Continued review of the weekly skin assessments dated December 13 or 22, 2010, revealed the Stage of the wound had not been assessed. Medical record review of the weekly Pressure Ulcer records dated December 3, 2010, revealed on the resident had a Stage 3 wound on the left foot which measured 1.0 cm X 1.1 cm. Continued review of the weekly skin assessments dated December 15, 22 or 28, 2010 revealed the Stage of the wound had not been assessed. Medical record review of the weekly Pressure Ulcer records dated December 9, 2010, revealed the resident had an unstageable wound on the right heel which measured 5.0 cm X 3 cm. Continued review of the weekly skin assessments	F 314	The Resident care Specialist were in-serviced by the SDC on 3/11/11 regarding Incontinence care and turning/repositioning needs as well as the kardex system. The Unit Managers will randomly audit the kardex of 5 residents weekly times 4 weeks then monthly times 3 months to determine if it listing includes incontinence and turning needs of the residents. The DON will review the kardex weekly times 4 weeks then monthly times 3 months for 5 random residents and compare it to the resident to determine if the care listed matches the care delivery. **HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** Results of the audits will be presented to the monthly QAA committee for 4 months. If issues are identified then modifications will be made and audits will continue.	

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 dated December 15, 22 or 28, 2010, revealed the Stage of the wound had not been assessed. Review of the facility's policy for skin management revealed, "...1. Upon admission, all residents are assessed for skin integrity by completing a head to toe physical assessment of skin condition and completing the "Braden Scale-For Predicting Pressure Sore Risk"...2. Following admission, the Braden Scale...will be completed weekly for 3 additional weeks (for a total of 4 weeks including admission)...5. In addition, the following forms are completed and placed with the resident's Treatment Record: a. Pressure Ulcer: Weekly Pressure Ulcer Record...18. Pressure Ulcers are measured and staged weekly in accordance with the Practice Guidelines..." Medical record review and interview on February 9, 2011, at 4:35 p.m., with the Registered Nurse (RN) #1/Treatment Nurse confirmed the facility's policy for assessment of the resident's risk for the development of a Pressure Ulcer had not been followed, and the resident's risk of developing a Pressure Ulcer had not been assessed weekly for a total of four weeks after admission. Medical record review and interview on February 9, 2011, at 4:35 p.m. with RN #1/Treatment Nurse confirmed the facility's policy for assessing the stage of Pressure Ulcers weekly had not been followed, and the stage of the wounds on the left foot was not assessed on December 15, 22, and 28, 2010; the stage of the wound on the buttocks had not been assessed on December 13 or 22, 2010; the stage of the wound on the left heel had not been assessed on December 15, 22 or 28, 2010; and the stage of the wound on the right	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13 heel had not been assessed on December 15, 22, or 28, 2010. Resident #19 was admitted to the facility on December 17, 2010, with diagnoses of Persistent Vegetative State, Deep Vein Thrombosis, Contractures, Tracheostomy, Traumatic Brain Injury, Quadriplegia, Chronic Decubiti (Pressure Ulcers) and Urinary Tract Infection. Medical record review of the hospital Discharge Summary dated December 17, 2010, revealed, "...continues to be bedbound...Chronic Decubitus Ulcers...local care, turn every 2 hours..." Medical record review of the MDS dated February 4, 2011, revealed the resident was in a Persistent Vegetative State; was totally dependent on staff for all activities of daily living; had a feeding tube; and had one Stage 1 and three Stage 4 Pressure Ulcers. Continued review of the MDS revealed Pressure Ulcer treatments included a pressure-reducing device for the bed, a turning/repositioning program, nutrition intervention, and treatment of the Pressure Ulcers with dressings and application of ointments/medications. Medical record review of the Braden Scale-For Predicting Pressure Sore Risk assessment dated December 24, 2010, January 13 and February 4, 2011, revealed the resident was at high risk for the development of Pressure Ulcers. Medical record review of a physician's order dated February 8, 2011, revealed, "...Tx (Treatment) to R (right) hip: Cleanse w/wc (with wound cleanser), blot dry. Apply Santyl to wound bed and skin prep to periwound area. Apply activated hydrofera blue to wound bed. Cover w/	F 314		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 14 bordered gauze. (Change) daily. Monitor periwound area q (every) shift for s/s (signs/symptoms) of infection, Monitor dsg (dressing) placement q shift." Medical record review of a physician's order dated February 8, 2011, revealed, "Tx to L (left) hip: Cleanse w/wc. Apply hydrocolloid dsg, (change) q 3 days & PRN (as needed). Monitor periwound area q shift for s/s (signs/symptoms) of infection, Monitor dsg placement q shift." Medical record review of a physician's order dated February 8, 2011, revealed, "...Tx to coccyx: Cleanse w/wc, blot dry. Apply hydrocolloid dsg. (Change) q 3 days & PRN. Monitor periwound area q shift for s/s of infection, Monitor dsg placement q shift." Medical record review of the resident's care plan dated February 4, 2011, revealed the Pressure Ulcers were related to "...Sensory perception...Moisture/incontinen...Decreased activity...Impaired mobility...Friction and shear problem..." Continued review of the care plan revealed the interventions to address the Pressure Ulcers included, "...Turn and reposition while in bed frequently for comfort and pressure reduction...Provide incontinence care after each incontinent episode...Measure and stage wound weekly using the pressure ulcer healing assessment form...Pressure ulcer treatment as ordered..." Review of the facility's policy for skin management revealed, "...the following forms are completed and placed with the resident's Treatment Record: a. Pressure Ulcer: Weekly	F 314		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 15 Pressure Ulcer Record...Pressure ulcers are measured and staged weekly in accordance with the Practice Guidelines..." Observation and interview on February 22, 2011, at 10:20 a.m., with the Registered Nurse (RN) #3 revealed the resident was slightly positioned on the right side, and a bordered gauze dressing was in place on the right hip and dated February 20, 2011. Interview at the time of the observation with RN #3 confirmed the dressing on the right hip was dated February 20, 2011, and a dressing change had not been done on February 21, 2011. Continued observation on February 22, 2011, at 10:20 a.m., revealed RN #3 and Certified Nursing Assistant (CNA) #3 positioned the resident on the right side. Observation revealed a Pressure Ulcer on the right lower buttock, one on the coccyx and one on the left buttock. Continued observation revealed the resident had been incontinent of a small to moderate amount of dark stool. Interview with RN #3, at the time of the observation, confirmed the resident was in need of incontinence care. Observation on February 22, 2011, at 10:29 a.m., with the Director of Nursing (DON) revealed the DON measured the Pressure Ulcers as follows: coccyx-4.0 cm x (by) 1.0 cm x 0.1; left buttocks-7.0 cm x 3.0 cm x 0.1 cm; and right buttocks-4.0 cm x 1.2 cm x 0.1 cm. Interview on February 22, 2011, at 11:10 a.m., at the nurses' station, with CNA #1 revealed CNA #1 "came on duty" at 6:00 a.m., and relieved the night shift CNA. CNA #1 reported, "...not assigned to (resident) today...just come over to help out..." Continued interview with CNA #1	F 314		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 16 revealed the resident was positioned on the side at 6:00 a.m., when CNA #1 took report from the night shift CNA and confirmed CNA #1 had not turned or repositioned the resident or checked the resident for incontinence since coming on duty. Interview on February 22, 2011, at 11:15 a.m., at the nurses' station with CNA #2, who was assigned to the resident, confirmed CNA #2 had not turned or repositioned the resident from 7:00 a.m., until 11:00 a.m., and confirmed the resident had not been checked for incontinence. Interview on February 22, 2011, at 2:15 p.m., with Licensed Practical Nurse (LPN) #3 revealed LPN #3 had "straightened" the resident's shoulders "enough to give the meds and a breathing treatment" earlier in the morning (February 22, 2011). Continued interview with LPN #3 confirmed LPN #3, "did not do a full turn" and did not perform incontinence care or any grooming or hygiene for the resident. Medical record review and interview with the Director of Nursing on February 22, 2011, at 1:47 p.m., in the office revealed weekly pressure ulcer assessments for the wounds on the left buttock, the right hip and the right buttock had been completed. Continued interview with the DON confirmed the facility had no evidence the weekly pressure ulcer assessments had been completed for the wound on the coccyx and the right buttock and confirmed the facility's policy for weekly assessment of pressure ulcers had not been followed. Telephone interview on February 24, 2011, at 1:47 p.m., with the DON revealed the DON had reviewed the medical record and interviewed	F 314		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17 staff, and the DON further confirmed no evidence weekly pressure ulcer assessments had been completed for the wounds on the coccyx and the right buttock. C/O #27271, #27297, #27531	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure the environment was free of accident hazards for one (#7) and failed to ensure safety devices were in place for three (#10, #13, #14) of twenty-two residents reviewed. The findings included: Resident #7 was admitted to the facility on October 27, 2010, with diagnoses including Septic Left Sacroiliac Joint, Right Retroperitoneal and Paraspinal Abscess, Anxiety, History of Cirrhosis secondary to Hepatitis C, Chronic Low Back Pain, Hypertension, Hypothyroidism, Anemia, and Frequent Urinary Tract Infections. Medical record review of the Minimum Data Set (MDS) dated October 27, 2010, revealed the resident had no impairment of decision-making	F 323	F323 **HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENCT PRACTICE?** Resident #7- the shower room grout has been repaired and no leaking water is observed at this time. This resident is no longer at the facility and no further actions can be taken. Resident #10 is no longer at the facility and no further actions can be taken. Resident #13 had a fall risk assessment completed on 3/14/11 by the DON with interventions that include pressure pad to bed and chair, non skid socks, fall mats to left side of bed. Care plan and Kardex match the devices listed and are in place. Resident #14 had a fall risk assessment completed on3/1/11 by the DON. Interventions include: pressure pad to bed and chair and the care Plan and Kardex matches the devices currently in place.	3/28/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18 skills; required limited assistance with bed mobility, transfers, and ambulation; and had no history of falls in the two to six months prior to admission to the facility. Medical record review revealed the resident was discharged home with home health on December 1, 2010. Medical record review of the "Fall Risk" assessment dated October 27, 2010, revealed the resident was not at risk for falls. Medical record review of a nurse's note dated November 17, 2010, revealed, "Resident states...was transferring in bathroom & (and) fell d/t (due to) water in floor. Spill cleaned up. Maintenance notified. Resident did not ask for assistance...getting up @ (at) time of fall..." Medical record review of the facility's investigation of the fall on November 17, 2010, revealed, "...Resident slipped on water in floor. Area was cleaned & Maintenance was notified..." Continued review revealed the resident did not require medical treatment after the fall. Observation and interview on February 15, 2011, from 11:00 a.m.-11:15 a.m., with the Maintenance Director in the central bath and in the room (where resident #7 resided), which adjoined the central bath, revealed the tile in the central bath had been replaced, and the grout around the tile had eroded leaving a "tiny crack" between the wall of the central bath and the bathroom wall of the resident's room. Continued interview with the Maintenance Director confirmed a small amount of water would leak into the resident's bathroom near the toilet when showers were given in the central bath. Continued observation and interview with the Maintenance Director confirmed	F 323	**HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** The Unit Managers and DON completed a walk through of the facility to identify current safety devices the residents are utilizing. The identified safety devices were compared to the care Plan and Kardex to determine if each matches the Plan of Care. **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** Nursing Admin (DON and Unit Managers) was in-serviced on fall prevention program on 3/18/11 by the Admin and SDC. This included investigations to determine if the safety devices were alarming at the time of fall.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19 a different colored grout had been applied to three walls of the central bath including the wall which adjoined the resident's room. Interview on February 15, 2011, at 2:25 p.m., with the Assistant Director of Nursing(ADON)/Falls Coordinator confirmed "no doubt" the resident's fall on November 17, 2011, was because of water in the bathroom floor, and the leak had been repaired by the Maintenance Director. Resident #10 was readmitted to the facility on October 19, 2010, with diagnoses including Throat Cancer, Osteoarthritis, Osteoporosis, Hemiparesis, Anxiety, Hypertension, History of CVA and Tracheostomy. Medical record review of the facility History and Physical dated October 20, 2010, revealed the resident was alert and oriented. Medical record review of the MDS dated November 24, 2010, revealed the resident had no impairment of decision-making skills and had no falls in the six months prior to admission to the facility. Medical record review revealed the resident expired in the facility on January 6, 2011. Medical record review of the "Fall Risk" assessments dated October 19 and November 24, 2010, and January 5, 2011, revealed the resident was at high risk for falls. Medical record review revealed the resident was observed sitting on the floor beside the bed on October 24 and December 6, 2010, with no apparent injury. Review of the facility's investigation of the fall revealed a pressure pad alarm and a "clip alarm" were put in place. Medical record review of a nurse's note dated December 14, 2010, at 4:00 a.m., revealed the	F 323	Licensed Nurses were in-serviced on fall prevention program on 3/11/11by the SDC that included investigation of events for placement of the safety devices was in place and alarms sounding if a falls occurs. An electronic kardex assignment sheet was developed for the Resident Care Specialist to utilize delivering care. The Kardex system was in-serviced to the RC's by the SDC. The Kardex will be updated M-F by the Unit Managers and if needed on Sat-Sun by the clinical supervisor. DON or Unit Managers will randomly audit 3 residents on each hall requiring safety devices each week times 4 weeks then monthly times 3 months to determine if the safety devices are in place and functioning correctly. **HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** Results of the random audits will be presented to the monthly QAA committee for 4 months. If identified issues are noted then modifications to this plan of correction will be made.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20 resident was observed on the floor beside the bed with "...L (Left) side of head bleeding...abrasion on L side of head..." Medical record review revealed no documentation the pressure pad and clip alarm were in place and operating at the time of the fall. Medical record review of the facility's investigation revealed "bolsters" were placed on the bed after the fall. Medical record review of a post fall review dated December 14, 2010, at 7:00 p.m., revealed, "...Resident observed lying on floor next to bed." Review of the facility's investigation of the fall on December 14, 2010, revealed no documentation the pressure pad and clip alarm were in place and operating at the time of the fall. Interview on February 16, 2011, at 10:50 a.m., in the office with the ADON/Falls Coordinator confirmed the resident had been assessed at high risk for falls, and the resident had fallen on October 24, December 6 and two separate times on December 14, 2010. Continued interview with the ADON/Falls Coordinator confirmed a pressure pad alarm, a clip alarm and bolsters had been put in place to reduce the risks of the resident falling. Continued interview with the ADON/Falls Coordinator confirmed the facility's policy for investigation of falls included making a determination of whether interventions, which had been put in place, were in place at the time of a fall. Continued interview with the ADON/Falls Coordinator confirmed the facility had no knowledge if the pad and clip alarms were in place at the time of the two falls on December 14, 2010. Continued interview with the ADON/Falls Coordinator confirmed the bolsters, which were put in place after the fall at 4:00 a.m., on December 14, 2010, "had not been put on tight	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21 enough and one had moved...had therapy instruct...on application of bolsters..." Resident #13 was admitted to the facility on August 27, 2010, with diagnoses including Hypertension, Anemia, End-Stage Renal Disease with Hemodialysis and Diabetes. Medical record review of the MDS dated December 20, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills; required extensive assistance with bed mobility and transfers; had an unsteady balance when moving from a seated to standing position, moving on and off the toilet and with transfers between the bed and chair; and had no history of falls in the six months prior to admission to the facility. Medical record review of "Fall Risk" assessments dated August 27 and December 20, 2010, and January 4, 2011, revealed the resident was at high risk for falls. Medical record review of a "IDT" (Interdisciplinary Team) nurse's note dated November 10, 2010, revealed, "fall on 11/2/10 @ 5:40 p.m. in room... (no) injury noted. Resident stated...had to go to bathroom & forgot to use call light. Intervention is clip alarm & education of resident..." Medical record review of a nurse's note dated December 25, 2010, revealed, "...sitting in floor beside bed. (No) injuries noted..." Review of the facility's investigation of the fall revealed no evidence the clip alarm was in place at the time of the fall. Continued review of the investigation revealed non-skid socks were placed on the resident.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22 Medical record review of a nurse's note dated January 4, 2011, revealed, "Res. sitting in floor @ bedside...trying to go to bathroom and slid out. (No) injuries noted..." Medical record review of a nurse's noted dated January 6, 2011, revealed, "...Res noted to be sitting in floor. (No) injuries noted..." Review of the facility's investigation of the falls on January 4 and 6, 2011, revealed no evidence the clip alarm or non-skid socks were in place at the time of the falls. Observation on February 14, 2011, at 9:50 a.m., and February 15, 2011, at 10:05 a.m., and 2:10 p.m., revealed the resident lying in bed with a pressure pad alarm in place. Interview on February 15, 2011, at 2:28 p.m., in the office, with the ADON/Falls Coordinator confirmed a clip alarm was put in place after the resident fell on November 2, 2010. Continued interview with the ADON/Falls Coordinator confirmed the ADON/Falls Coordinator observed the clip alarm was not in place at the time of the fall on December 25, 2010; confirmed the facility had no knowledge if the clip alarm was in place at the time of the falls on January 4 and 6, 2011; and confirmed non-skid socks were not in place at the time of the fall on January 6, 2011. Resident #14 was admitted to the facility on May 27, 2010, with diagnoses including Dementia, Gastrointestinal Reflux Disease and Fractured Hip with Left Hemi-Arthroplasty. Medical record review of the MDS dated December 7, 2010, revealed the resident had no impairment of decision-making skills; required extensive assistance with bed mobility, transfers and ambulation; was unsteady when moving from a seated to a standing position, ambulating, moving	F 323		

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23 on and off the toilet and transferring between the bed and chair; was incontinent of bowel and bladder; and had a history of falls in the prior one to six months prior to admission. Medical record review of the fall risk assessments dated May 27, June 3, September 7, and December 7, 2010, revealed the resident was at high risk for falls. Review of a "Change of Condition" dated December 12, 2010, revealed, "...Heard clip alarm. Found resident in floor sitting up beside bed...no injuries noted..." Review of the facility's "Interdisciplinary Post Fall Review" dated December 12, 2010, revealed, "...Had slid off...bed...will apply bolsters as long as air mattress in use...Intervention Recommendations:...clip alarm..." Medical record review of a nurse's note dated December 17, 2010, revealed, "Found resident in floor sitting beside bed. No injury noted..." Medical record review of the facility's investigation of the fall dated December 17, 2010, revealed the resident reported "trying to get up." Observation on February 14, 2011, at 9:00 a.m., revealed the resident lying in bed with a clip alarm in place. Observation on February 14, 2011, at 9:10 a.m., revealed the resident lying in bed with a clip alarm in place. Observation on February 15, 2011, at 9:20 a.m., revealed the resident lying in bed on the left side. Observation revealed the base of the clip alarm	F 323		

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 was secured on the headboard, but the clip was not visible. Observation and interview on February 15, 2011, at 9:25 a.m., with Licensed Practical Nurse (LPN) #1 revealed LPN #1 raised the resident's pillow, and the clip had been removed from the cord. Interview with LPN #1 confirmed the clip alarm was not attached to the resident. Observation on February 15, 2011, at 2:15 p.m., revealed the resident was sitting in a chair at the bedside with the base of the clip alarm secured on the back of the chair and the clip alarm attached to the resident's shirt. Observation on February 16, 2011, at 12:58 p.m., revealed the resident sitting in a chair at the bedside with the base of the alarm secured to the back of the chair and the cord and clip was dangling down the side of the chair and was not attached to the resident. Observation and interview on February 16, 2011, at 1:23 p.m., with Registered Nurse #2/Staff Development Coordinator confirmed the clip alarm was not attached to the resident. C/O #26871, #27171, #27223, #27271, #27297	F 323		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514	F514 HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENCT PRACTICE? Resident #6 had a skin assessment completed on 3/2/11 by the Licensed Nurse. The assessment identified no new skin issues. Orders are in place that includes signatures indicating the treatment is being provided for the right lower extremity skin lesion. Resident #10 is no longer in the facility and no further actions can be made for him.	3/28/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 25 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the medical record was complete for two (#6, #10) of twenty-two residents reviewed. The findings included: Resident #6 was admitted to the facility on March 14, 2006, with diagnoses including Severe Dementia, Alzheimer's Disease, Hypertension, Seizure Disorder and Peripheral Vascular Disorder. Medical record review of the Minimum Data Set dated October 28, 2010, revealed the resident had short and long-term memory problems and severely impaired decision-making skills and was totally dependent on staff for all activities and daily living. Medical record review of the "Non-Pressure Skin Condition Report" dated January 20, 2011, revealed, "...R (right) shin...lesion...1.0 (centimeters)...area dried, scabbed...crusty covering. Cover (with) dry dsg (dressing). (Change) QD (every day)." Continued review of the assessment revealed the documentation did not include the name of the resident; a description of the characteristics of the wound or wound bed; and a description of drainage. Medical record reveiw of a physician's order	F 514	**HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Licensed Nurses were in-serviced on wound care documentation expectations by the Don and SDC including A) weekly skin checks with documentation describing the wound. B) Treatment orders for all identified areas that includes the cleaning agent, wound treatment, and cover dressing (if appropriate). **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** A weekly skin audit of 5 random residents will be conducted by the DON and Unit Managers times 4 weeks then monthly for 3 months to validate if the documentation matches the care being provided. The audits will also validate if the signatures are being documented on the TAR's indicating the treatment is being provided.	

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 26 dated January 20, 2011, revealed, "Clean area to R lower ext (extremity) (with) NS (normal saline), pat dry, apply dry dsg (change) QD & (and) prn (as needed)." Medical record review of the "Head to Toe Skin Checks" dated January 26, 2011, revealed the documentation did not identify the resident. Medical record review of the Treatment Record dated January 20-31, 2011, revealed no documentation wound care was provided on Janaury 21, 22, 24, 25, 28, 29, 30, 31, 2011. Observation on February 7, 2011, at 10:35 a.m., revealed the resident was positioned in a reclined geri chair with a gauze bandage on the right lower leg. Telephone interview on February 28, 2011, at 2:15 p.m., with Licensed Practical Nurse (LPN) #4 confirmed LPN #4 had reviewed the "Non-Pressure Skin Condition Report" dated January 20, 2011, and confirmed LPN #4 performed the assessment, and the documentation did not include the name of the resident; a description of the characteristics of the wound or wound bed; and a description of drainage. Telephone interview on February 28, 2011, at 2:25 p.m., with LPN #5 confirmed LPN #5 had reviewed the "Head to Toe Skin Checks" dated January 26, 2011; had performed the assessment; and the skin check did not identify the resident. Telephone interview on February 28, 2011, at 3:25 p.m., with the Director of Nursing	F 514	**HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?** Results of the random audits will be presented to the QAA committee monthly times 4 months. If identified issues are noted then modifications will be made to this plan of correction.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 27 (DON)confirmed the DON had reviewed the Treatment Record dated January 20-31, 2011, and there was no documentation wound care had been provided on January 21, 22, 24, 25, 28, 29, 30, 31, 2011. Resident #10 was admitted to the facility on October 19, 2010, with diagnoses including Cancer of the Base of the Throat, Malnutrition, Anxiety, Hemiparesis (paralysis on one side), Tracheostomy and History of Cerebrovascular Accident (Stroke). Medical record review of the Minimum Data Set dated October 29, 2010, revealed the resident had moderately impaired decision-making skills. Medical record review of the nursing admission assessment dated October 19, 2010, revealed a Stage 2 wound on the left sacral area, "...0.03 (centimeter) X (by) 0.03 circular opening..." and a Stage 1 on the coccyx "with Duoderm cover." Continued review of the nursing admission assessment dated October 19, 2010, revealed the assessment had not been signed or dated by the nurse. Medical record review and interview on February 9, 2011, at 4:03 p.m., with the Director of Nursing in the Social Worker's office confirmed the initial nursing assessment dated October 19, 2010, had not been signed or dated by the nurse. C/O #26879, #27271, #27297, #27531	F 514		